

**UGS/WPS CLMA Meeting
September 30, 2005**

UGS Questions and Answers

1. Regarding the date of service for specimens collected over a period of greater than 24 hours: I have a reference in the Federal Register (Vol. 70, No 37, pp. 9355-9358) that seems to indicate that the date the collection ends is the correct date of service. However, we are not clear that this is the final rule. Is it indeed the final rule? Have WPS and UGS included the change in their communications to providers?

A: UGS believes that this is the final rule and it does specify that the date collection ends should be the date of service. We have not included this in any communications to providers.

2. When does a post “benign biopsy” patient return to screening mammogram status? We have been converting them back to screening after (1) year. Our coders think they are diagnostic for the rest of their lives.

A: A diagnostic mammography is a radiological procedure furnished to a man or woman with signs and symptoms of breast disease, or a personal history of breast cancer, or a personal history of biopsy- proven benign breast disease, and includes a physician’s interpretation of the results of the procedure. A diagnostic mammography is a covered service if a doctor of medicine or osteopathy as defined in § 1861(r) (1) of the Act orders it.

3. We have been having a real problem with UGS and magnesium. The denial code is 5L16P, LMRP U01.19.01 and NCD L1978. Any assistance would be greatly appreciated. CPT code 83735.

A: From the example that was sent by the provider the diagnosis code is not covered by Medicare. Diagnosis code 25002 doesn’t fall within the coverage range of 250.10-260.93.

4. When we order a urinalysis and a urine culture with an acceptable ICD-9 code that satisfies the NCD for the urine culture, why are we receiving rejections from FISS? Do we need to have a separate ICD-9 code for the urinalysis and culture?

Example 1: Urinalysis, urine culture, organism ID, and organism sensitivity submitted. ICD-9 code of 599.0 submitted. Everything but the organism sensitivity was denied. This code is acceptable per the NCD. The urinalysis was performed and the culture was added when the urinalysis was found to be abnormal.

A: Everything was paid on the claim example submitted to UGS, LLC.

5. When we submit claims for screening or pre-op work, why does FISS tell us that we cannot bill the patient after they deny the claim? Medicare excludes most screening lab work by statute and will not pay. What do we need to do when we submit the claim in order to bill the patient?

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Example 1: Lipid panel ordered with an ICD-9 code of V70.0 submitted. This is a code for a routine medical exam. It is my understanding that in 2004 Medicare did not pay for “screening” lipid panel. The denial code was B-22 and FISS said we could not bill the patient. Even though we did not need to, we collected an ABN.

Example 2: Lipid panel ordered with an ICD-9 code of V77.91 submitted. We collected an ABN on this patient also.

Example 3: Urine culture ordered with an ICD-9 code of V72.83 submitted. We collected an ABN on this patient. This is a screening code and the claim was denied. FISS says we cannot bill the patient.

A: (1) In these situations, the provider billed the service in question as covered. The bill went through the NCD module, found no covered diagnosis and correctly denied the line as provider liable, as there is no modifier present to shift to the beneficiary. The exclusion diagnoses codes were not the only codes on the bill. The system denied the service PL correctly. Please refer to CR 3115 and 3416 for guidance.

This occurs because non-covered lab was billed incorrectly. If a visit and laboratory work is only for the purpose of excluded services the liability rests with the beneficiary. However, the provider needs to bill correctly, for the system to be able to read this on the bill.

If the excluded service is the only service provided on a given day, then the provider does not have to bill the service(s) to Medicare. If the beneficiary disputes that the service is excluded, and wants a bill submitted, the provider should bill the service with a condition code 21 and bill the charges non-covered.

If other covered services are rendered on the same day as the non-covered service, the provider should bill just that line non-covered, and should append a modifier GY to the line. This will allow the system to assign liability to the beneficiary.

The GY modifier can be used for:

- **Items or services statutorily excluded or does not meet the definition of any Medicare benefit**
- **Non-covered by Medicare statute(ex., service not part of recognized Medicare benefit)**
- **Optional notice only, unless required by COPs; It is incorrect to issue an ABN for an excluded service**
- **Beneficiary liable**
- **Use on all types of line items on provider claims**
- **Lines submitted as non-covered and will be denied**

6. I was under the impression that hospital laboratories must bill Medicare for their inpatients and outpatients, including those tests performed by an outside entity, such as tests sent to a reference lab (58 FR 43837). Recently I have been hearing that some labs believe the rule has changed and that the reference lab can/should bill Medicare for these tests. Also, does UGS

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require the -90 modifier for these tests (the description in the CPT codebook says that the modifier "may" be added)? What is the rule for this?

A: In the case of a clinical laboratory test provided under an arrangement (as defined in [§1861\(w\) \(1\)](#)) made by a hospital, CAH or SNF, payment is made to the hospital or SNF.

NOTE: Laboratory services provided to a SNF inpatient under Part A are billed by the SNF, not the laboratory, due to consolidated billing for SNFs. You may also reference Publication 100-4, Chapter 16, Section 40.3 on the CMS website under Internet Only Manuals. Finally, UGS requires modifier 91 when appropriate on laboratory services.

7. Can a patient who needs a transfusion be pre-registered as a hospital outpatient prior to the visit so the type, screen and cross-match can be completed ahead of time? The specific instance this occurs is nursing homes, oncology centers and dialysis centers. They would like the lab to draw the blood from the patient in these settings, type and crossmatch, and then send the patient to the hospital as an outpatient for the transfusion. Are there reasons why the patient cannot be registered as an outpatient until they physically arrive at the hospital? If this is the case, the crossmatch cannot begin until arrival?

A: Patients are frequently pre-registered in outpatient hospital settings. We do not know of any edits that would stop the type, screen and cross-match from processing. A submitted example of this to UGS would be helpful.